Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

RAYMOND L FORBES
210 BAILEY LOOP
KYLE TX 78640-4639

Respondent Name:
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number:
M4-12-0105-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Reimbursement for workers comp medical expenses."

Amount in Dispute: $1,206.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not respond to the request for medical fee dispute resolution. The insurance carrier representative signed for their copy of the dispute on September 15, 2011.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2010	Out of Pocket Medical Expenses – Office Visit	$20.00	$ 20.00
December 22, 2010	Out of Pocket Rx Expense	$10.00	$ 10.00

December 22, 2010	Out of Pocket Medical Expenses – CT Scan	$32.85	$ 32.85
December 22, 2010	Out of Pocket Medical Expenses – Lab Fees	$15.00	$ 0.00
December 28, 2010	Out of Pocket Medical Expenses – Office Visits	$20.00	$ 20.00
December 29, 2010	Out of Pocket Medical Expenses – Surgical Procedure	$1108.80	$1108.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for Claimants to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for Claimants to submit workers' compensation medical receipts to the insurance carrier for reimbursement of out of pocket expenses.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits were not submitted by either party. The Respondent has not submitted documentation to support that the receipts the Claimant submitted to TPA Sedgwick CMS were reviewed.

Issues

1. Did the requestor submit the receipts to the respondent for the out of pocket expenses in accordance with 28 Texas Administrative Code §133.270?
2. Is the requestor entitled to reimbursement?

Findings

The requestor submitted fax cover sheets, dated January 4, 2011 and June 22, 2001, to TPA Sedgwick CMS pursuant to 28 Texas Administrative Code §133.270 and 28 Texas Administrative Code §133.307(c)(3)(D).

Pursuant to 28 Texas Administrative Code §133.307(c)(3)(C) the requestor has submitted receipts showing out of pocket expenses in the amount of $1,191.65. The Claimant submitted a Claim Detail from United Healthcare showing the laboratory services were not covered but did not submit a receipt showing services in the amount of $15.00 was paid by the Claimant; therefore, reimbursement for the laboratory services are not recommended.

Pursuant to 28 Texas Administrative Code §133.270(c) the insurance carrier shall pay or deny the request for reimbursement within 45 days of the request. Reimbursement shall be made in accordance with §134.1 (relating to Medical Reimbursement). The respondent has neither denied nor paid the Claimant for out of pocket expenses relating to the workers' compensation injury.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,191.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $1,191.65 reimbursement for the disputed services.

Authorized Signature

October 6, 2011

Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c)), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.